ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES (HFS)
PRIOR AUTHORIZATION REQUEST FORM
TOPAMAX (Topiramate)

A. PHYSICIAN INFORMATION - Complete ALL Information Below:

Physician Name: _____ DEA #: _____ License #: _____

Is Prescriber a Neurologist? Yes ☐ No ☐ If not, list specialty. _____ Office Phone #: _____

B. PHARMACY INFORMATION - Complete ALL Information Below:

Pharmacy Name: _____ Pharmacy ID: _____ Pharmacy Phone #: _____

C. PATIENT INFORMATION - Complete ALL Information Below:

Patient Name: _____ DOB: _____ __/__ ____/ Patient 9 Digit IDHFS Recipient Number: _____

List All Relevant Diagnoses:

Is Patient Developmentally Disabled? Yes ☐ No ☐ If yes, please incidate dose requested in section D. Then complete section G

D. NON-PREFERRED MEDICATION JUSTIFICATION Complete **ALL** Information Below:

Target Dose and Dosing Schedule Anticipated: _____

☐ **Topamax 25 mg. Tablet GCN 36553** ☐ **Topamax 25 mg. Cap GCN 36556** ☐ **Topamax 100 mg. Tablet GCN 36551**
☐ **Topamax 25 mg. Cap GCN 36557** ☐ **Topamax 50 mg. Tablet GCN 36550** ☐ **Topamax 200 mg. Tablet GCN 36552**

Circle each Drug(s) used for this patient from the appropriate Seizure type*

Seizure type	First line agent	Second line agent
Generalized tonic-clonic	Carbamazepine Lamotrigine Valproate	Levetriacetam Oxcabazepine
Absence	Ethosuximide Lamotrigine Valproate	Clonazepam
Myoclonic	Valproate	Clonazepam Lamotrigine Levetiracetam Piracetam
Tonic	Lamotrigine Valproate	Clonazepam Levetiracetam
Atonic	Lamotrigine Valproate	Clonazepam Levetiracetam
Focal with or without secondary generalization	Carbamazepine Lamotrigine Oxcarbazepine Valproate	Gabapentin Levetiracetam Phenytoin Tiagamine
LGS or severe mixed	Lamotrigine Valproate	Clonazepam Ethosuximide Levetiracetam

If request is for diagnosis other than seizure disorder, list all drugs tried/failed:

F. ADDITIONAL INFORMATION - Please include any relevant information you wish to be considered during review.

IMPORTANT: To prevent delay, fax relevant patient information with this form to validate request.

G. PHYSICIAN OR DESIGNEE SIGNATURE

_____ _____
Signature **Date**

*Adapted from National Institute of Clinical Excellence. *The Epilepsies: The Diagnosis and Management of the Epilepsies in Adults and Children in Primary and Secondary Care. 2004*

PLEASE COMPLETE ALL INFORMATION TO ENSURE PROMPT PROCESSING
N 10/3/2005

FAX TO: 217-524-7264
ATTN: MEDICAL COMMITTEE